CHEST: Clear to auscultation. Good air exchange. No retractions.

CARDIAC: Regular rate and rhythm. No murmurs, rubs or gallops.

ABDOMEN: Soft. Nontender. Nondistended. No hepatosplenomegaly. No guarding or rebound. No masses or bruits. Bowel sounds present.

PELVIS: Stable, nontender.

EXTREMITIES: No cyanosis, clubbing or edema. No Homans' sign. Nontender.

NEUROLOGICAL EXAMINATION: As stated above.

HEENT: Demonstrated what appeared to be a very fine petechial rash across the face. There was no subconjunctival hemorrhage. The pharynx was moist without stridor. When the patient initially arrived, he was in this state and subsequently was given 0.5 mg of Ativan in his line that was established by EMS; however, it was determined that this line was actually infiltrated, so this first half of a mg of Ativan was probably subcutaneous. The patient subsequently had another IV established in the emergency department by us in the right forearm and was given a further 0.25 mg of Ativan. At 2105 hours, he was more sedate. At 2114 hours, his pupils were 4 mm and slightly reactive at this point; however, his mental status was still unchanged. At 2130 hours, the patient was in CAT scan. At 2155 hours, he continued to be resting more comfortably, mental status still unchanged. Glasgow coma scale was estimated to be 9.

I did speak with Children's Hospital physician, Dr. Chaddha at 2117 hours, he did accept the patient to the Children's Hospital of Pittsburgh Emergency Department. I did advise him that LifeStar in Erie was ready to fly the patient at 2116 hours, and he was agreeable to let them fly the patient down. Of note, early in the patient's emergency department care, I had spoke with the Hamot intensivist, Dr. De Joya at 2114 hours. He stated that given the fact that there was no pediatric intensivist at Hamot that a flight to a tertiary care hospital for this patient's management would be most appropriate. The patient's father was agreeable with this transfer and did sign consent for this. LifeStar subsequently did arrive in the emergency department at 2155 hours and given the fact that the patient had just had an emesis, decided to intubate the patient to protect his airway. They did proceed to do this and subsequently transferred the patient to Children's Hospital of Pittsburgh.

The patient received a total of 1 mg of Ativan prior to his disposition from the emergency department and then subsequently did receive some IV medications by LifeStar prior to the intubation.

LABORATORY & X-RAY DATA: Included a portable chest x-ray which was no active disease, but did show a large amount of gastric air. This was read by me. CT scan of the head was no radiographic abnormality; that was the official report. White count was 14.0 with a normal automated differential. Hemoglobin was 11.3. Platelets were 464,000. Sodium was 139, potassium 3.3, chloride 100, bicarbonate 23, BUN 17, creatinine 0.5. Calcium was 9.0. Glucose was 169.

FINAL DIAGNOSIS: Anoxic encephalopathy, traumatic asphyxia, secondary to accidental chest wall compression.

DISPOSITION: The patient was LifeStar'd to Children's Hospital of Pittsburgh's Emergency Department for definitive treatment of his hypoxic encephalopathy. I provided this patient of one hour of critical care.

Peter M. Intrieri, MD

PMI/ara

cc:

PATIENT NAME	DICTATED BY	M.R. NO.	ROOM	DISCHARGE DATE
Ford, Ryan C	Peter M. Intrieri, MD	38-27-39	ED ED-018	

DOCUMENT NUMBER	DATE DICTATED	DATE TRANSCRIBED	TYPE OF REPORT	
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